STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B058003	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	1189 HWY 77 MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations are the result of a survey for re-licensure conducted on 9/4/18, 9/5/18, 9//6/18 and 9/10/18 at the above named home plus facility in Marysville, KS.	S 000		
S5028 SS=D	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	S5028		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B058003	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	1189 HWY 77 MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5028	Continued From page 1 KAR 26-42-101 (f) (3) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for 1(#905) sampled resident, the operator failed to ensure that allegation of abuse and neglect was reported to the department within 24 hours, an investigation was started when the operator was notified of an alleged violation, each allegation was thoroughly investigated, appropriate corrective action taken, and the department's complaint investigation reports was completed and submitted to the department within five working days of the initial report. Findings included: - Record review for resident # 905 recorded admission date of 3/12/18 with diagnoses of: dementia, hypothyroidism, depression and hypertension. Functional Capacity Screen dated 6/5/18 recorded resident required assistance with walk/mobility and unable to perform transfers and management of medications and treatments. Resident has a history of falls, has problems with long term memory, short term memory, memory recall and decision making. Resident has problems with communication: sometimes understandable/sometimes understands. Negotiated Service agreement addendums dated 6/5/18 recorded resident to receive 1-2 person assist with gait belt for all transfers (abilities vary throughout the day), and 2- assist with gait belt during ambulation. Home will store and administer all medications and treatments. Resident is a fall risk due to left side weakness,	S5028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B058003	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	1189 HWY 77 MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5028	Continued From page 2	S5028		

staff will give frequent redirection and allow ample time for resident to respond.

Nurses notes dated 8/29/18 at 1:10pm recorded the following: "At 7:15am resident noted sitting on floor with buttocks on back of bilateral lower extremities (BLE) upper body still wrapped in comforter, both feet visible .... Resident could not explain events. When asked if he/she was in pain, resident stated 'yes' ... ... Passive ROM (range of motion) performed to BLE, BUE (bilateral upper extremities) WNL (within normal limits). Hospice notified of fall ....9:00am resident noted to have episodes of apnea, difficult to arouse .... Daughter notified of fall and apnea. ..... 3:00pm: hospice nurse arrives at 1:40pm ... requested order from Doctor ... ." Signed by operator/licensed nurse #A.

Interview on 9/5/18 at 2:40pm with operator/licensed nurse #A confirmed resident could not tell him/her what happened for fall of 8/29/18, stated he/she did investigate the event and believed the resident to have fallen out of bed tangled in the blanket. He/she stated night aide would have been in the room at 6:00am. He/she confirmed it was unknown how long resident was on the floor. He/she did not report the incident of unknown cause to the department and confirmed lack of record of investigation of the fall.

For resident #905, the operator failed to ensure that allegation of abuse and neglect was reported to the department within 24 hours, an investigation was started when the operator was notified of an alleged violation, each allegation was thoroughly investigated, appropriate corrective action taken, and the department's complaint investigation report was completed and submitted to the department within five working

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B058003	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	1189 HWY 77 MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5028	Continued From page 3 days of the initial report when a cognitively impaired resident fell, was unable to communicate how the fall happened and it was unknown how/when resident fall occurred.	S5028		
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review, observation and interview for 3(#904, 905, 906) sampled residents, requiring health care services, the operator failed to ensure that a licensed nursed provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #904 recorded admission date of 5/14/18 with diagnoses of:	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B058003	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	1189 HWY 77 MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 4 Alzheimer's, diabetes mellitus type 2, and constipation. Functional Capacity Screen (FCS) dated 6/5/18 recorded resident independent with transfers and walk/mobility and unable to perform management of medications and treatments. Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) addendums dated 6/5/18 recorded resident independent with transfers, walk/mobility (uses a cane), home will store and administer all medications and treatments. Observation on 9/4/18 at 3:45pm in resident's room revealed a bed cane (loop) attached to the left side of resident's bed. HCSP lacked entry for resident use of a bed cane for transfers. Interview on 9/5/18 at 2:00pm with operator/licensed nurse #A confirmed resident has a bed cane to help resident pull up in bed. He/she confirmed HCSP lacked entry for resident use of a bed cane. Record review for resident # 905 recorded admission date of 3/12/18 with diagnoses of: dementia, hypothyroidism, depression and hypertension. FCS dated 6/5/18 recorded resident required assistance with walk/mobility and unable to perform transfers and management of medications and treatments. NSA/HCSP addendum dated 6/5/18 recorded resident to receive 1-2 person assist with gait belt	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B058003	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	1189 HWY 77 MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 5	S5155		

for all transfers (abilities vary throughout the day), and 2- assist with gait belt during ambulation. Home will store and administer all medications and treatments.

Observation on 9/5/18 at 1:30pm in resident's room revealed resident in bed with 2 half side rails in up position on resident's bed.

Interview on 9/5/18 at 2:40pm with operator/licensed nurse #A confirmed resident has side rails for positioning. He/she confirmed HCSP lacked entry for resident use of side rails. He/she also confirmed resident required assistance to exit the building in case of an emergency and HCSP lacked entry for evacuation assistance.

HCSP lacked entry for resident use of side rails and assistance for emergency evacuation.

Record review for resident #906 recorded admission date of 8/3/18 with diagnoses including: Parkinson's, hallucinations, hypotension, dysphagia, degenerative joint disease and glaucoma.

FCS dated 8/13/18 recorded resident required assistance for transfers, walk/mobility, and was unable to perform management of medications and treatments.

NSA/HCSP dated 8/13/18 recorded resident required partial assist for all transfers and a wheelchair for mobility, home will store and administer all medications and treatments.

Observation on 9/4/18 at 3:45pm in resident's room revealed 2 quarter side rails in up position on resident's bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B058003	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	1189 HWY 77 MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 6 Interview on 9/5/18 at 2:00pm with operator/licensed nurse #A confirmed resident has side rails but does not know if resident uses them. He/she confirmed HCSP lacked entry for resident use of side rails. He/she also confirmed resident required assistance to exit the building in case of an emergency and HCSP lacked entry for evacuation assistance. HCSP lacked entry for resident use of side rails and assistance for emergency evacuation. For residents #904, 905, 906 requiring health care services, the operator failed to ensure that a licensed nursed provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S5155		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B058003	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	1189 HWY 77 MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5215	Continued From page 7 shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3) The census equaled 8 the sample included 3 residents. Based on record review and interview, the operator failed to ensure quarterly review of the disaster and emergency preparedness plan with residents and staff. Findings included: - On 9/6/18, requested documentation of the facility's emergency management plan reviews for staff and residents. Documentation included evacuation drills with staff and residents on 3/24/18 and 7/19/18 and tornado preparedness in-service on 4/25/18 and 6/9/18 with staff. Facility records lacked documentation of quarterly reviews of the disaster plan with staff and residents. Email dated 9/6/18 from facility operator/licensed nurse #A confirmed facility reviewed disaster plan with staff upon hire, however he/she has not conducted quarterly reviews of the plan with staff and residents. For all residents, the operator failed to ensure quarterly review of the disaster and emergency preparedness plan with residents and staff.	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B058003	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	1189 HWY 77 MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5301	Continued From page 8	S5301		
S5301 SS=F	26-42-205 (d) (3) Facility Administration of Medications (d) (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(3)(D) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for all residents, the operator failed to ensure that if the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide document the actual clock time the medication is administered as evidenced by record review for residents # 904, 905 and 906. .	S5301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B058003	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	1189 HWY 77 MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5301	Continued From page 9 Findings included: - Record review for resident #904 recorded admission date of 5/14/18 with diagnoses of: Alzheimer's, diabetes mellitus type 2, and constipation. FCS dated 4/30/18 recorded resident unable to perform management of medications and treatments. NSA/HCSP dated 5/14/18 recorded home will store and administer all medications and treatments. MAR/TAR for September 2018 recorded 33 medications and treatments with administration times of AM (morning) PM (afternoon) HS (bedtime) and PRN (as needed) including: Synthroid (thyroid) 88 mcg (micrograms) tablets take 1 tablet PO (by mouth) daily 'take on empty stomach': administration time; AM. MAR/TAR lacked actual clock times medications were administered. Record review for resident # 905 recorded admission date of 3/12/18 with diagnoses of: dementia, hypothyroidism, depression and hypertension. Functional Capacity Screen (FCS) dated 6/5/18 recorded resident unable to perform management of medications and treatments. Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 6/5/18 recorded Home will store and administer all medications	S5301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B058003	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	1189 HWY 77 MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5301	Continued From page 10 and treatments. Review of Medication and Treatment record (MAR/TAR) for September 2018 recorded 11 medications and treatments recorded with administration times of AM (morning) PM (afternoon)and PRN (as needed) including Levothyroxine (thyroid) 25 mcg (micrograms) tablets take 1 tablet PO (by mouth) daily: administration time; AM. Manufacturer's recommendations for administration of Levothyroxine (generic for Synthroid): take on an empty stomach 30 minutes to 1 hour before breakfast. MAR/TAR lacked actual clock times medications were administered. Record review for resident #906 recorded admission date of 8/3/18 with diagnoses including: Parkinson's, hallucinations, hypotension, dysphagia, degenerative joint disease and glaucoma. FCS dated 8/13/18 recorded resident unable to perform management of medications and treatments. NSA/HCSP dated 8/13/18 recorded home will store and administer all medications and treatments. September MAR/TAR recorded 15 medications with administration times of AM, PM, HS and PRN. MAR/TAR lacked actual clock times medications were administered.	S5301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B058003	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	1189 HWY 77 MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5301	Continued From page 11 Interview on 9/5/18 at 2:30pm with operator/licensed nurse confirmed all residents received medication and treatment management assistance and MAR/TAR lacked actual times administered for most medications. For all residents, the operator failed to ensure that if the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide document the actual clock time the medication is administered as evidenced by record review for residents # 904, 905 and 906. .	S5301		
S5328 SS=F	26-42-205 (l) (3) Medication Regimen Review Documentation (3) The administrator or operator, or the designee, shall ensure that the medication regimen review is kept in each resident ' s clinical record. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (l)(3) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for 3 sampled residents (#904, 905, 906), the operator failed to ensure a licensed pharmacist or nurse conducted a medication regimen review at least quarterly for each resident whose medication is managed by the facility and each time the resident experiences any significant change in condition.	S5328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B058003	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	1189 HWY 77 MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5328	Continued From page 12 The operator, or the designee, shall ensure that the medication regimen review is kept in each resident's clinical record. Findings included: - On 9/5/18 requested medication regimen reviews for residents #904, 905, 906 who received medication assistance. Operator/ Licensed nurse #A presented 2 documents from a nurse consultant review dated 4/12/18 and 8/13/18 stating medication records had been reviewed. Documents lacked names of residents reviewed and findings of resident reviews. Resident roster recorded all residents received medication assistance. Record review for resident # 904 recorded admission date of 5/14/18 Record review for resident #905 recorded admission date of 3/12/18, Record review for resident #906 recorded admission date of 8/3/18 Records lacked evidence of quarterly pharmacy reviews. Interview on 9/5/18 with operator/licensed nurse #A confirmed all residents received medication assistance and records lacked documentation of each resident's medication review by the nurse consultant. For all residents of the facility, (based on review	S5328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B058003	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	1189 HWY 77 MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5328	Continued From page 13 of records for residents #904, 905, and 906) the operator failed to ensure a licensed pharmacist or nurse conducted a medication regimen review at least quarterly for each resident whose medication is managed by the facility and each time the resident experiences any significant change in condition. The operator, or the designee, shall ensure that the medication regimen review is kept in each resident's clinical record.	S5328		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437 (a) The facility reported a census of 8 residents. The sample included 3 residents. Based on observation and interview for all residents, the operator failed to ensure the facility was maintained to protect the health and safety of the residents when chemicals were unsecured throughout the facility. Findings included:	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B058003	A. BUILDING: _____ B. WING _____	09/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIGHTHOUSE	1189 HWY 77 MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5335	Continued From page 14 - Observation on 9/4/18 from 3:12pm to 3:30pm during independent facility tour, revealed unsecured chemicals at 3 locations about the facility: In the open concept kitchen under the sink, in a cabinet with a broken magnetic lock, 8 containers of chemicals including: Bleach, 1 gallon; Cascade dishwasher packets, 78 packets; Cerma bryte cook top cleaner, 10 ounces; and Fabuloso cleaner 32 ounces. In the hallway behind movable bifold screens: Lysol spray 19 ounces; and comet cleanser 25 ounces. In the hall closet behind unlocked bifold doors, on an easily reachable shelf: Bissel carpet cleaner 48 ounces and Oxy carpet pet fresh odor eliminator 42.6 ounces. Resident roster dated 9/4/18 recorded all residents had impaired cognitive status. For all residents, the operator failed to ensure the facility was maintained to protect the health and safety of the residents when chemicals were unsecured throughout the facility.	S5335		